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Core Principles in Treating Suicidal Patients

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The treatment of suicidal individuals requires special attention to therapist interventions that promote a viable treatment alliance in the context of shared responsibilities for patient safety. Three core principles in the treatment process (alliance building, enhancing curiosity about the function of suicidal thoughts and urges, as well as enhancing experience and expression of intense emotions) are articulated and brief case vignettes are used to illuminate the principles. Results from open trails and randomized control trials involving suicidal patients are examined to support the evidence-based practice of these principles. The overarching principle undergirding the utility of the principles is a collaborative joining with the patient to decrease isolation and alienation when facing intense and overwhelming emotions.

Keywords: therapeutic alliance, radical curiosity, expression of affect, suicide risk

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Working with suicidal patients is the single most challenging and anxiety-provoking task facing therapists (Jobes, 1995), presenting unique challenges to the process and outcome of psychotherapy. The therapist's fear of losing a patient to suicide can impair the capacity to think flexibly about the patient's inner experience, attend to countertransference reactions, and can lead to ruptures in the therapeutic alliance (Allen, 2011; Bateman & Fonagy, 2006; Hendin, 1981). When a therapist's capacity to flexibly attend to the patient and the therapeutic process breaks down, the therapeutic alliance and the quality of the therapeutic enterprise can rapidly shift to chronic crisis management and away from the prime objective of helping the patient deal more effectively with intense, often overwhelming emotions that drive the suicidal crisis.

When undertaking a treatment with a seriously suicidal patient, I work toward helping the patient: (1) optimize a treatment frame and therapeutic alliance to balance autonomy and responsibility for safety so that both parties can genuinely agree to the goal of decrease the allure of suicide as a solution to life's problems, (2) enhance the patient's (as well as the therapist's) capacity to be curious about the function and symbolic significance of suicidal thoughts, and (3) enhance the patient's capacity to experience and express a broad range of emotions during sessions. When provided in the spirit of collaboration and empathic acceptance, these technical objectives can enhance the therapeutic alliance, open the patient's curiosity about their suicidal states, and decrease the overall risk, all of which can function to avert potential iatrogenic power struggles that can derail an otherwise effective treatment.

For the past 2 decades, the majority of my patients have made medically serious suicide attempts in the weeks and months before our first meeting. Many come to my office frustrated that they are still alive and insisting they would prefer to be dead. These high-risk patients have taught me a great deal about the therapeutic benefits of remaining interested in them as people as they struggle with thoughts of death by suicide. Whatever else I may have to say about treatment interventions, the efficacy of specific interventions hinge on my ability to communicate an emotionally present, appropriately empathic, and deep curiousity about the reasons they would rather be dead than alive.

Optimizing the Treatment Frame and Initial Alliance

In the first session with high-risk patients I work toward the following goals: (1) assess the patient's current suicide risk, (2) communicate my interest in better understanding why they want to die, and (3) assess the capacity to negotiate the shared and differential responsibilities of managing safety in the form of a plan for managing suicidal crises.

Patients presenting for treatment with active suicidal ideation and intent must be assessed for risk (see Fowler, 2012, for a review of suicide risk assessment strategies). Rather than conducting a formal suicide interview, I generally integrate my evaluation as we discuss the patient's current struggles. I want to communicate my interest in their suffering and to invite them to speak openly about their reasons for wanting to be dead. In our exchange, I work to understand the patient's reasons for wanting to be dead and attempt to provide a tolerable empathic response to their suffering in the form of marked mirroring (Bateman & Fonagy, 2006).

All too often therapists turn quickly to security operations and medico-legal risk management strategies that inadvertently send the message that the patient may not be able to trust the therapist with their thoughts and feelings. Struggling with suicidal thoughts alone, or worse, needing to hide their impulses and emotions, further alienates the patient. At the same time, therapists cannot work effectively if a solid frame is not established to secure an agreement that the patient is working on similar goals. Thus, a prerequisite for establishing a therapeutic

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alliance is negotiating a commitment to therapy and how suicidal crises will be managed.

Therapy Vignette

Esther was a middle-aged mother of three whose neighbor discovered her comatose and cyanotic 12 hours after an overdose.[1] After several weeks and intensive care, she was cleared for psychiatric treatment. The recent medically serious suicide attempt and current ideation suggested that she was at high-risk for repeat suicide attempt. Her chief complaint was of protracted depression, interpersonal anxiety, and an intractable desire to be dead.

Her first words to me conveyed a detached, world-weary futility, "I just don't know, I really have no reason to go on living and I just want to sleep." I did not focus on the immediate risk but rather asked, "What is it about sleep that is so alluring to you?"

She described a 5-year course of disappointments leading her to feel unwanted and uncared for by family. After 20 min of describing the many precipitants to her suicide attempt, she again stated her wish to be dead and her deep regret that she was not successful in killing herself. I remarked, "It's very clear that you have been suffering for a long time. It sounds like you have decided to throw in the towel on your life." She agreed in the lackluster tone, then added: "Oh, why bother . . . talking can't help anything and all I want is to sleep forever." I said in turn, "I'm fairly confident that you can kill yourself anytime that you chose; but, you are sitting here with me, which makes me wonder if there's not something that you want for your life in addition to your death." Esther appeared to relax in her chair. I then added, "You can be asleep for an eternity if you kill yourself, but I'm wondering if we could find out what is behind your suicidal thoughts and wishes and see if you get help you with the problems that drive these thoughts?"

Esther's demeanor and speech pattern shifted from apathy and determined insistence on death to modest curiosity. She asked, "So what kind of things do you think might be driving this?" It was clear that we had not yet established a treatment contract, but she seemed to be trying me out for the role of therapist. I responded, "There were several things you said that made me think that you struggle with the disappointments that your family does not appreciate all of your good efforts to provide them with a good life."

At this, Esther showed the first spark of life as her eyes widened with surprise, that I understood her need to be appreciated. She quickly countered that this could not be the only reason she wants to be dead. I fully agreed that I could not know the answers and genuinely need her help in developing a fuller understanding of her wish to die and sleep forever.

I then added,

"I want to hear everything that you can tell me about your suicidal thoughts, your fantasies, and what you think it would be like after you are dead. I will listen carefully and work to help you discover solutions to your suffering. I will do my best to hold your suicidal urges and intentions in mind, to provide a space for you to talk freely about them without overreacting. I do not need you to reassure me that you are safe or out of the woods. I simply would like you to consider setting aside any imminent plans for killing yourself for 6–8 weeks while we begin to work on this puzzle together."

Supporting Evidence

One of the prime modifiable protective factors for suicide is the experience of positive supportive relationships between patient and clinician (APA, 2003), and clinicians of various theoretical backgrounds work to establish and enhance a positive therapeutic relationship. To create the conditions in which a viable therapeutic alliance has a chance of developing, it is necessary to establish a basic therapeutic framework. Leading experts in the treatment of suicidal patients generally agree that having a clear plan for dealing with suicidal crises that involve patients' active participation and management of seeking support is essential for establishing the frame (Bateman & Fonagy, 2006; Linehan, 1993; Rudd et al., 1999; Stanley, Brown, & VonBergen, 2008). In Esther's case, negotiating a plan to set aside suicide for a trial period of treatment, and establishing a plan for contacting friends when overwhelmed, was a viable alternative to no self-harm contracts. It also placed greater emphasis on potentially positive collaborative work together, thus enhancing the possibility of a viable therapeutic alliance. I deliberately work toward securing a commitment to treatment that may hold appeal for the patient rather than insisting they agree to a no self-harm contract (Rudd, Mandrusiak, & Joiner, 2006).

Treatments that emphasize the development of a strong therapeutic alliance, exploration of affect, and attending to repairing ruptures in the alliance appear to exert a powerful influence on the patient's degree of hope for the future, and in reducing suicide risk (Bateman & Fonagy, 2008; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Doering et al., 2010; Linehan et al., 2006). The collaborative assessment and management of suicidality intervention (CAMS: Jobes, Louma, Jacoby, & Mann, 1998; Jobes, 2011) is a suicide-specific manualized treatment to help patients and clinicians establish and maintain a therapeutic alliance while the pair works to understand the meanings and functions of suicidal ideation. Open trials of the CAMS approach demonstrate decreased suicidality among outpatients (Jobes, Kahn-Greene, Greene, & Goeke-Morey, 2009; Jobes, Wong, Conrad, Drozd, & Neal-Walden, 2005) and psychiatric inpatients (Ellis, Green, Allen, Jobes, & Nadorff, 2012).

Enhancing Curiosity About the Function of Suicidal Thoughts

A hallmark of the suicidal mode of thinking is a foreclosure on flexible cognition about the internal emotional problems driving suicidal ideation (Allen, 2011; Fowler et al., 2012; Maltsberger, 2004; Rudd, 2000). Working to help restore or bolster the capacity to reflect on internal emotional and cognitive processes (primarily of the self, but also of the other) is a core feature of several treatments for suicidal individuals (see Allen, 2011, for a thorough review of the topic). In my practice I try to enhance the patient's curiosity about their certitude that suicide is the only option for dealing with painful experiences. Much of this is communicated through modeling my curiosity about how their mind works and raising questions about the multiple functions that suicidal ideation can serve.

[1] Esther is a fictional name. Minimal details about the patient's life were disclosed to protect confidentiality.

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Therapy Vignette

Several days later, Esther complained of great difficulty sleeping because she was troubled by suicidal ruminations. Her mood was dour and she made no eye contact during the first minutes of the session. To open a space for exploration, I asked, "What were you thinking about when the suicidal ruminations started?" She began by explaining that she was thinking of all the people who had disappointed her and how no one in her life really loved her as she was. I asked her to consider what may have been going on in her mind before the assertion that no one loves her. She retreated, saying she had no idea. I returned with enthusiasm, "Fantastic, a mystery for us to investigate!" She seemed dubious of my enthusiasm, but stated she had been isolating in a room and was feeling low. I focused on the emotionally tinged word "low," "What does *low* feel like?" She sheepishly explained that she made dinner for her roommate but then felt depressed and excused herself before eating. I continued to follow the emotional thread "When you left the table, did any fleeting thoughts or feelings pass through your mind?" She added, "I know this sounds stupid, but I wished she would just ask me what was wrong. I must have lain in bed forever waiting for her to knock on my door—I'm pathetic!" The self-attack was immediate and appeared as an all-encompassing emotional storm that riveted her attention inward. To break into the self-hatred, I said, "Just a moment ago you described feeling needful, wishing that your roommate would reach out to you, then it appeared as though you are attacking yourself for having needs. No doubt you feel terrible about yourself; but, I have to tell you that I do not find your needs pathetic or stupid. I do find myself wondering what life experiences you've had that could lead you to believe that having needs and wants mean that you are pathetic?"

Esther did not appear to register my differentiated assessment of her feeling state, but did take up the question regarding the etiology of her beliefs, "I think I've always felt this way. Even as a little girl I felt ashamed for wanting a hug from my parents. Our family wasn't very 'touchy-fealy.' And I always felt like an outcast, like I didn't belong with the rest of them." Esther's willingness to consider my curiosity opened the way to exploring her long history of ingratiating behaviors aimed at evoking a caring response from others as a creative (though not terribly effective) response to a neglectful home environment.

Supporting Evidence

Suicidal states are often triggered by unbearably painful emotions associated with feeling abandoned, alone, alienated, and disconnected. In those most vulnerable to suicide, the capacity to think clearly and flexibly collapses, and suicide emerges as a means of escaping unbearable pain (Fowler et al., 2012; Maltsberger, 2004; Shneidman, 1993). Treatments that focus on restoring the capacity to reflect on strong emotions, and to weather affective storms are emerging as highly effective in reducing the occurrence of suicide-related behaviors (Bateman & Fonagy, 2008; Clarkin et al., 2007; Doering et al., 2010; Linehan et al., 2006). Techniques aimed at improving tolerance for, and improved modulation of, intense affect include radical acceptance, mindfulness acceptance, insight-oriented interpretation, and mentalizing, to name a few. In my practice I use all elements to fit the needs of the patients but rely heavily on enhancing the patient's curiosity about their emotions because suicidal patients like Esther are nearly phobic of negative emotions.

Experiencing and Expressing Affect

It is widely accepted that overwhelming painful emotions can cause a breakdown in cognitive capacities, increasing the risk of suicide for vulnerable individuals (Fowler, Hilsenroth, & Piers, 2001; Fowler et al., 2012; Hendin et al., 2010; Maltsberger, 2004; Shneidman, 1993). Increasing the suicidal patients' understanding, acceptance, and regulation of intense affects is a necessary component of treatment to produce lasting change.

Therapy Vignette

After Esther's self-attack for being pathetic, I invited us to explore her reactions. As she spoke of her alienation from family and friends I noticed the exceptionally bland and detached tone of her voice. I attempted to amplify the signal of her resentment and sorrow over thwarted longings by imagining aloud how upset she must feel—she remained detached from the immediate emotion. I then recalled an earlier moment in the session in which she described drawing the shades closed in her living room as a way of shutting out the world. I said, "I have a strange thought . . . as you were describing your reactions to your longings, I could almost see the shades being pulled down over *you* right now. I thought what a tragedy that even here with me you have to suppress your emotions, and hide away your true feelings." With this, Esther began to weep as she described years of feeling taken for granted by her family no matter how much she did for them. She felt guilty about having resentment toward her family. Her emotions peaked as she complained bitterly about her husband's indifference. Guilt and self-castigation followed immediately as she insisted she had no right to feel this way. I responded, "It is incredibly difficult for you to express these emotions, and I sense the pain this causes you. At the same time, I am sitting on the other side of the room filled with a sense of hope and promise that you are no longer completely alone with these feelings, no longer hiding behind the drawn shades." For the second time she began weeping as she confessed, "I have felt so alone. I hate these feelings. I'm not supposed to resent my children, I'm not supposed to be angry at my husband. I'm supposed to be the one who takes care of them!" And then as if to punctuate the futility of the therapy enterprise she added wistfully, "Oh, why bother. It's all such a waste. I don't deserve anything from anybody and I'm just a selfish person. Look at me, I'm crying like a little baby when I have no right to feel like this."

Sensing that she was shifting to an unmanageable level of self-loathing, I worked to help her titrate the emotional experience by invoking her cherished role as a mother. First, I marveled over the fact that as adults we can override our natural predilections for experiencing and expressing emotions in ways that toddlers never do. I then wondered aloud, "I am sure you have memories of your children when they were needful. When they were little, how did they respond when they needed or wanted something and couldn't get it?"

She chuckled, then shifted back to futility. I asked, "What made you chuckle a moment ago?" She paused then added, "I don't know. It's just this memory of my son standing at the refrigerator

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screaming bloody murder because he was hungry. It makes me happy to think that he could be so intense about needing something to eat, *immediately!*" On further reflection she realized it filled her heart with joy to know that she could fulfill some of his needs and it made her long for the times when she was needed. I wondered aloud if it could be possible for Esther to express her needs more directly, "Could it be that some people in your life might feel needed if you were to express a need?" Her response was immediate, "Oh! My mother would *love* to be needed that way now that she is retired. I'm just not sure that I want to be taken care of the way she wants to do it." I added, "Maybe your needs are different now, but I do wonder if expressing your needs, regardless of the other person's capacities to fill them, would be freeing to you. Maybe we can help you discover what can make expressing your needs more tolerable. If so, it might protect you from sinking into such a state of despair and hopelessness that you feel like killing yourself." Esther tolerated the notion of exploring the barriers to expressing a wider range of emotions, as it did not imply that she would be required to "emote on demand."

Supporting Evidence

This exchange highlights the degree to which many suicidal patients block and suppress strong emotions only to have those internalized into self-hatred and self-destructive urges. It also illuminates the benefits of marked mirroring as a technique for both empathizing with the patient's momentary expression of emotion while providing a differentiated mental experience of the therapist. Mentalization-based treatment (Bateman & Fonagy, 2006), dialectical behavioral therapy (DBT: Linehan, 1993), and CAMS (Jobes, 2011) advocate a collaborative and inquisitive approach to the suicidal patients' thoughts and feelings rather than a confrontational or authoritarian style. These modalities place a premium on helping patients develop skills in understanding, tolerating, and modulating the intensity of affect storms in order to decrease the vulnerability to suicide and self-destructive behaviors. Randomized controlled trials of mentalization-based treatment and dialectical behavioral therapy demonstrate clear and compelling evidence that these treatments help borderline patients decrease the frequency of self-destructive behaviors (Bateman A, Fonagy, 2008; Linehan et al., 2006; Verheul et al., 2003). Recent evidence indicates that durable gains can be achieved with decreased suicide attempts and service use, improved global psychiatric functioning, and reduced ratings of borderline functioning at 5-years posttreatment with long-term mentalization-based treatment (Bateman & Fonagy, 2008).

Conclusions

Esther continued to struggle with the belief that she should not experience or express negative emotions; yet, over the course of a brief intensive treatment, she learned to tolerate these feelings when they emerged without resorting to self-hatred and suicidal thoughts. In our final session, she described how helpful it had been to learn more about her pattern of interpersonal ingratiation, avoidance of expressing her emotions, and the value of expressing her needs more directly. Importantly, she expressed mixed feelings about seeing me, "I wish I never had to come see you . . . I really hate therapy! But, I'm sure glad it was you I had to see."

The anxiety-filled work of treating suicidal patients can lead many clinicians to foreclose an exploration and understanding of the patient's reasons for suicidal urges. I adopt a radical curiosity about the reasons and functions of their suicidal thoughts and feelings to enhance the therapeutic alliance, increase the patient's curiosity about the multiple functions suicidal ideation, and enhance their capacity to accept, tolerate, and modulate their emotional experiences. Integrating these interventions into my practice and teaching these principles through supervision has not been easy. We are intermittently pulled by our fears of losing a patient to suicide, but I have yet to encounter a patient who benefitted from an adversarial or confrontational approach to their suicidal thoughts and feelings. I owe a debt of gratitude to my patients who have taught me how to approach them, and to innovators like Marsha Linehan, David Jobes, Anthony Bateman, and Peter Fonagy for systematizing treatment protocols that help us join the patient in quieting emotional storms and decrease suicide potential.

References

Allen, J. G. (2011). Mentalizing suicidal states. In K. Michel & D. A. Jobes (Eds.), *Building a therapeutic alliance with the suicidal patient* (pp. 81–91). Washington, DC: American Psychological Association. doi:10.1037/12303-005

American Psychiatric Association. (2003). *American Psychiatric Association: Practice guideline for the assessment and treatment of suicidal behaviors*. Arlington, VA: American Psychiatric Publishing.

Bateman, A., & Fonagy, P. (2006). *Mentalization based treatment for borderline personality disorder: A practical guide*. New York: Oxford University Press.

Bateman, A., & Fonagy P. (2008). Eight-year follow-up of patients treated for borderline personality disorder: Mentalization-based treatment versus treatment as usual. *The American Journal of Psychiatry, 165,* 631–638. doi:10.1176/appi.ajp.2007.07040636

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *The American Journal of Psychiatry, 164,* 922–928. doi:10.1176/appi.ajp.164.6.922

Doering, S., Hörz, S., Rentrop, M., Fischer-Kern, M., Schuster, P., Benecke, C., . . . Buchheim, P. (2010). Transference-focused psychotherapy v. treatment by community psychotherapists for borderline personality disorder: Randomised controlled trial. *The British Journal of Psychiatry, 196,* 389–395. doi:10.1192/bjp.bp.109.070177

Ellis, T. E., Green, K. L., Allen, J. G., Jobes, D. A., & Nadorff, M. (2012). Collaborative assessment and management of suicidality in an inpatient setting: Results of a pilot study. *Psychotherapy, 49,* 72–80. doi:10.1037/a0026746

Fowler, J. C. (2012). Suicide risk assessment in clinical practice: Pragmatic guidelines for imperfect assessments. *Psychotherapy, 49,* 81–90. doi:10.1037/a0026148

Fowler, J. C., Hilsenroth, M. J., Groat, M., Biedermann, C., Biel, S., & Ackerman, S. (2012). Risk factors for medically serious suicide attempts: Evidence for a psychodynamic formulation of suicide crisis. *Journal of the American Psychoanalytic Association, 60,* 555–576. doi:10.1177/0003065112442240

Fowler, J. C., Hilsenroth, M. J., & Piers, C. (2001). An empirical study of seriously disturbed suicidal patients. *Journal of the American Psychoanalytic Association, 49,* 161–186. doi:10.1177/00030651010490010901

Hendin, H. (1981). Psychotherapy and suicide. *American Journal of Psychotherapy, 35,* 469–480.

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Hendin, H., Al Jurdi, R. K., Houck, P. R., Hughes, S., & Turner, B. L. (2010). Role of intense affects in predicting short-term risk for suicidal behavior: A prospective study. *Journal of Nervous and Mental Disease, 198,* 220–225. doi:10.1097/NMD.0b013e3181d13d14

Jobes, D. A. (1995). The challenge and the promise of clinical suicidology. *Suicide and Life-Threatening Behavior, 25,* 437–449.

Jobes, D. A. (2011). Suicidal patients, the therapeutic alliance, and the collaborative assessment and management of suicidality. In K. Michel, D. A. Jobes, K. Michel, & D. A. Jobes (Eds.), *Building a therapeutic alliance with the suicidal patient* (pp. 205–229). Washington, DC: American Psychological Association. doi:10.1037/12303-012

Jobes, D. A., Kahn-Greene, E., Greene, J., & Goeke-Morey, M. (2009). Clinical improvements of suicidal outpatients: Examining suicide status form responses as moderators. *Archives of Suicide Research, 13,* 147–159. doi:10.1080/13811110902835080

Jobes, D. A., Luoma, J. B., Jacoby, A. M., & Mann, R. E. (1998). *Manual for the collaborative assessment and management of suicidality (CAMS).* Unpublished manuscript, The Catholic University of America, Washington, DC.

Jobes, D. A., Wong, S. A., Conrad, A., Drozd, J. F., & Neal-Walden, T. (2005). The Collaborative assessment and management of suicidality vs. treatment as usual: A retrospective study with suicidal outpatients. *Suicide and Life-Threatening Behavior, 35,* 483–497. doi:10.1521/suli.2005.35.5.483

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford.

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., . . . Lindenboim N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy versus therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry, 63,* 757–766. doi:10.1001/archpsyc.63.7.757

Maltsberger, J. T. (2004). The descent into suicide. *The International Journal of Psychoanalysis, 85,* 653–667. doi:10.1516/3C96-URET-TLWX-6LWU

Rudd, M. D. (2000). The Suicidal Mode: A Cognitive-Behavioral Model of Suicidality. *Suicide and Life-Threatening Behavior, 30,* 18–33.

Rudd, M. D., Mandrusiak, M., & Joiner T. E., Jr. (2006). The case against no-suicide contracts: The commitment to treatment statement as a practice alternative. *Journal of Clinical Psychology, 62,* 243–251. doi:10.1002/jclp.20227

Rudd, M. D. Joiner, T. E., Jobes, D. A., & King, C. A. (1999). The outpatient treatment of suicidality: An integration of science and recognition of its limitations. *Professional Psychology: Research and Practice, 30,* 437–446. doi:10.1037/0735-7028.30.5.437

Shneidman, E. S. (1993). Suicide as psychache. *Journal of Nervous and Mental Disease, 181,* 145–149. doi:10.1097/00005053-199303000-00001

Stanley, B., Brown, G. K., & VonBergen, H. A. (2008). *Safety plan treatment manual to reduce suicide risk: Veteran version*. Washington, DC: United States Department of Veterans Affairs.

Verheul, R., van den Bosch, L. M., Koeter, M. W., De Ridder, M. A., Stijnen, T., & van den Brink, W. (2003). Dialectical behaviour therapy for women with borderline personality disorder: 12-month, randomised clinical trial in the Netherlands. *The British Journal of Psychiatry, 182,* 135–140. doi:10.1192/bjp.182.2.135

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